Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012940	A. BUILDING: _____ B. WING _____	C 11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF CROWN POINT	140 E 107TH AVENUE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00159263. Complaint IN00159263-Substantiated. No deficiencies related to the allegations are cited. Survey date: November 14, 2014 Facility number: 012940 Provider number: 012940 AIM number: N/A Survey team: Regina Sanders, RN, TC Census bed type: Residential: 28 Total: 28 Census payor type: Other: 28 Total: 28 Sample: 6 Bickford of Crown Point was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00159263. Quality Review 11/17/14 by Lisa McColly	R 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE